DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15067

State File No.

FILED MAY 8 1944

Registration District No. 114 Primary Registration District No. 3035 Registrar's No. 24

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1901 Bloom
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4/14 (Specify whether years, months or days)
In this community Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette 54
(c) City or town Lexington 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1901 Bloom
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME Matthew Matthews
3. (b) If veteran, name war —
3. (c) Social Security No.

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased November (Month) (Day) 1871 (Year)

8. AGE: Years 73 Months 7 Days — If less than one day — hr. — min.

9. Birthplace Lexington (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Insurance
11. Industry or business —

FATHER
12. Name Matthew Matthews
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Matthews
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cora Wills
(b) Address Lexington, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-44 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn
18. (a) Signature of funeral director —
(b) Address Lexington, Mo
19. (a) April 20-44 (Date received local registrar) (b) Mrs. Fred Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18
year 1944 hour 5:20 minute A. m. M.
21. I hereby certify that I attended the deceased from April 7, 1943, to April 18, 1944,
that I last saw him alive on April 17, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Metastasis to Leptomeninges	42
Due to: Cepto-adeno carcinoma	
Due to: Obs. hepatitis	
Other conditions (Include pregnancy within 3 months of death): —	
Major findings: Of operations —	
Of autopsy —	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? — (e) Means of injury —

23. Signature Leo C. West M.D.
Address Lexington, Mo Date signed 4/18/44

115-8 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 5-5-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

MAY 10 1944

Signed George H. Green

Licensed Embalmer No. 4220

P. O. Address 204 E. 24th St. Lexington, Ky.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
43
36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 174 Primary Registration District No. 3035 Registrar's No.

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Matthew Matthews
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race B
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) (Day) 1870 (Year)
8. AGE: Years 73 Months 7 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 18 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lipts-adeno-carcinoma of sixth rib and left breast — primary seat of the malignancy	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN Underline the cause to which death should be charged statistically.
Of autopsy	

50

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

SUPPLEMENTARY

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Geo. C. West (M.D. or other)
Address Lexington, Mo Date signed

15067